



DEPARTMENT OF THE NAVY

BOARD FOR CORRECTION OF NAVAL RECORDS

2 NAVY ANNEX

WASHINGTON DC 20370-5100

JRE

Docket No: 6994-98

24 August 1999



Dear [REDACTED]

This is in reference to your application for correction of your naval record pursuant to the provisions of title 10 of the United States Code, section 1552.

A three-member panel of the Board for Correction of Naval Records, sitting in executive session, considered your application on 29 July 1999. Your allegations of error and injustice were reviewed in accordance with administrative regulations and procedures applicable to the proceedings of this Board. Documentary material considered by the Board consisted of your application, together with all material submitted in support thereof, your naval record and applicable statutes, regulations and policies.

After careful and conscientious consideration of the entire record, the Board found that the evidence submitted was insufficient to establish the existence of probable material error or injustice. In this connection, the Board substantially concurred with the rationale of the hearing panel of the Physical Evaluation Board which reviewed your case on 24 April 1997. It noted that the military departments, unlike the Department of Veterans Affairs (VA), rate only those conditions which render a service member unfit for duty, or contribute to an unfitting condition and warrant a separate rating. It was not persuaded that any of the additional conditions rated by the VA in your case were unfitting or should have been rated by the Department of the Navy. Accordingly, your application has been denied. The names and votes of the members of the panel will be furnished upon request.

It is regretted that the circumstances of your case are such that favorable action cannot be taken. You are entitled to have the Board reconsider its decision upon submission of new and material evidence or other matter not previously considered by the Board. In this regard, it is important to keep in mind that a presumption of regularity attaches to all official

records. Consequently, when applying for a correction of an official naval record, the burden is on the applicant to demonstrate the existence of probable material error or injustice.

Sincerely,

W. DEAN PFEIFFER  
Executive Director

Enclosure

[REDACTED]

**RATIONALE:**

THE MEMBER IS A 30 YEAR OLD PN3, USN WITH ABOUT 3 AND 1/2 YEARS OF SERVICE AT THE TIME OF HER APPEARANCE BEFORE A MEDICAL BOARD AT PORTSMOUTH NAVAL HOSPITAL ON 23 AUGUST 1996 WITH THE DIAGNOSES:

- (1) RECALCITRANT RIGHT PATELLOFEMORAL SYNDROME, STATUS POST RIGHT ANTERIOR CRUCIATE LIGAMENT RECONSTRUCTION;
- (2) POSSIBLE LATERAL MENISCAL TEAR;
- (3) CHRONIC LOW BACK PAIN; AND
- (4) CHRONIC CERVICAL THORACIC SYNDROME.

THE PEB RECORD REVIEW PANEL CONSIDERED THE CASE ON 15 JANUARY 1997 AND FOUND THE MEMBER UNFIT FOR DUTY BECAUSE OF PHYSICAL DISABILITY BASED ON DIAGNOSIS NUMBER 1, WITH DIAGNOSIS NUMBER 2 CONSIDERED A CATEGORY II CONDITION, AND RATABLE AT 10% UNDER V.A. CODE 5299-5003; DIAGNOSES NUMBERS 3 AND 4 WERE CONSIDERED CATEGORY III CONDITIONS. THE MEMBER DISAGREED WITH THIS FINDING AND DEMANDED A FORMAL HEARING.

A FORMAL HEARING WAS CONDUCTED 24 APRIL 1997 WITH CAPTAIN W. H. FISHER, USNR, AS PRESIDING OFFICER AND [REDACTED] USMC, AND [REDACTED] MC, USN, AS PANEL MEMBERS. THE MEMBER WAS REPRESENTED BY LIEUTENANT [REDACTED].

THE MEMBER APPEARED AT THE FORMAL HEARING REQUESTING TO BE FOUND UNFIT FOR DUTY WITH DISABILITY RATINGS OF 30% UNDER V.A. CODE 8100, 10% UNDER V.A. CODE 5295, AND 10% UNDER V.A. CODE 5299-5003, FOR A COMBINED RATING OF 43% ROUNDED TO 40% AND PLACEMENT ON THE TDRL. THE MEMBER ALLEGED THAT SHE FIRST HAD PROBLEMS WITH HER KNEE ON THE USS HUNLEY WITH INCREASED PAIN FROM GOING UP AND DOWN LADDERS AND CAUSING HER KNEE TO GIVE OUT RESULTING IN A FALL DOWN SEVERAL STEPS; THAT SHE NOW HAS DIFFICULTY WITH PROLONGED STANDING OR WALKING FOR MORE THAN 10 MINUTES; THAT SHE CANNOT RUN OR SQUAT AND HAS TO WEAR AN ACL BRACE FOR EXERCISE; THAT SHE HAS HAD SEVERE LOW BACK PAIN SINCE 1993; THAT A SIGN FELL ON HER NECK AT A MALL; THAT THE CONDITION IMPROVED WITH PHYSICAL THERAPY BUT GOT WORSE AFTER THE THERAPY WAS DISCONTINUED; THAT BECAUSE OF THE BACK PAIN, SHE CANNOT SIT FOR MORE THAN 10 MINUTES WITHOUT TWISTING AND STRETCHING AND CANNOT LIFT MORE THAN 10 POUNDS OR BEND OVER; THAT SHE REQUIRES TREATMENT WITH PAMELOR, FLEXERIL AND MOTRIN AND HAS HAD TO GO TO THE E.R. TWICE FOR HER BACK; THAT SHE FIRST HAD PROBLEMS WITH HEADACHES IN 1993; THAT THESE GOT WORSE IN THE PAST YEAR AND GOT TO THE POINT THAT SHE JUST COULD NOT TAKE IT AND WENT TO MEDICAL; THAT SHE WAS REFERRED TO NEUROLOGY BECAUSE THE OTHER DOCTOR'S COULD NOT CONTROL THEM; THAT LIGHT AND FUMES TRIGGER HER HEADACHES; THAT THE MEDICATIONS (DEPAKOTE, CAFFERGOT, REGLAN, AND FIORINAL) ARE HELPING BUT THE HEADACHES ARE STILL THERE; THAT SHE DID A STUDY ON THE INTERNET AND HAS ELIMINATED POTENTIAL DIETARY TRIGGERS FROM HER DIET; AND THAT SHE DOES NOT FEEL SHE COULD CONTINUE IN THE NAVY DUE

TO THE HEADACHES IF THAT WERE HER ONLY MEDICAL PROBLEM. TO SUPPORT HER REQUEST THE MEMBER PRESENTED A MEDICAL BOARD ADDENDUM FROM NEUROLOGY DATED 24 FEBRUARY 1997, COPIES OF HER HEALTH RECORD ENTRIES MADE SUBSEQUENT TO THE SUBMISSION OF THE MEDICAL BOARD, COPIES OF HER LIGHT DUTY AND SIQ SLIPS, AND NON-MEDICAL EVIDENCE LETTERS FROM HER SUPERVISOR, A CO-WORKER, AND A FRIEND. THE MEMBER ALSO MADE HER HEALTH AND SERVICE RECORDS, X-RAYS, AND MEDICATIONS AVAILABLE FOR REVIEW.

AFTER CAREFUL REVIEW OF ALL THE AVAILABLE EVIDENCE AND BASED ON UNANIMOUS OPINION, THE HEARING PANEL FINDS THE MEMBER IS UNFIT FOR FULL DUTY IN THE U.S. NAVY BECAUSE OF PHYSICAL DISABILITY. THE RECORD AND EVIDENCE PRESENTED SHOWS THAT THE MEMBER HAS CHRONIC RIGHT KNEE AND LOWER BACK PAIN THAT LIMIT HER ACTIVITIES AND INTERFERE WITH THE ADEQUATE PERFORMANCE OF REQUIRED MILITARY DUTIES.

THE RECORD SHOWS THAT THE MEMBER WAS PREDISPOSED TO THE DEVELOPMENT OF RIGHT KNEE PAIN DUE TO A PRESERVICE INJURY THAT HAD RESULTED IN A TORN ANTERIOR CRUCIATE LIGAMENT THAT REQUIRED SURGICAL REPAIR AT AGE 16. AFTER ENTERING THE NAVY IN FEBRUARY 1993, THE MEMBER FIRST WENT TO MEDICAL FOR KNEE PAIN IN JUNE 1993 AFTER A 2 MILE P.T. RUN. THE KNEE PAIN BECAME CHRONIC AND WORSENER WHEN ASSIGNED ABOARD THE USS HUNLEY AND LATER SUSTAINED A TWISTING INJURY TO THE KNEE. THEREFORE, THE CONDITION WAS DEFINITELY AGGRAVATED BY MILITARY SERVICE. THE CURRENT MEDICAL BOARD REPORTED THE EXAM TO SHOW WELL HEALED SURGICAL INCISIONS, TENDERNESS TO PALPATION ALONG THE PATELLAR AND LATERAL PATELLAR FACET, TENDERNESS TO PATELLAR COMPRESSION, POSITIVE QUADRICEPS ATROPHY, POSITIVE QUADRICEPS INHIBITION WITH PATELLAR COMPRESSION, FULL RANGE OF MOTION, MILD PATELLOFEMORAL CREPITANCE, A 1+ LACHMAN'S, 1+ ANTERIOR DRAWER, NEGATIVE PIVOT SHIFT, NEGATIVE MCMURRAY'S, SOME MILD LATERAL JOINTLINE TENDERNESS, AND NO VARUS OR VALGUS LAXITY. X-RAYS WERE REPORTED TO SHOW MILD TO MODERATE PATELLOFEMORAL DEGENERATIVE CHANGES, AS WELL AS A BONE TUNNEL IN THE TIBIAL PLATEAU FROM HER CRUCIATE LIGAMENT RECONSTRUCTION. THIS IS CONSIDERED TO WARRANT A DISABILITY RATING OF 10% UNDER V.A. CODE 5257 OR 5299-5003. SINCE THE PATELLOFEMORAL PAIN SYNDROME SEEMS TO BE THE PREDOMINANT CONDITION AND THE MEDICAL BOARD INDICATED THAT SHE DID NOT HAVE TRUE INSTABILITY TYPE SYMPTOMS, THE LATTER V.A. CODING IS USED. BASED ON THE PRESERVICE INJURY AND SURGERY, AN EPTE FACTOR OF 0% IS APPROPRIATELY SUBTRACTED.

THE MEMBER DEVELOPED CERVICAL, THORACIC, AND LOWER BACK PAIN AFTER A SIGN FELL ON HER HEAD AND NECK AT A MALL IN FEBRUARY 1995. SYMPTOMS IMPROVED WITH PHYSICAL THERAPY BUT CONTINUED TO HAVE LOWER BACK PAIN WITHOUT RADICULAR SYMPTOMS. SHE CONTINUED TO REQUIRE TREATMENT WITH PAMELOR AND DAYPRO. EXAM WAS REPORTED TO SHOW TENDERNESS TO PALPATION ALONG THE LOWER LUMBAR PARASPINAL MUSCLES WITHOUT VERTEBRAL SPINOUS PROCESS TENDERNESS OR NEUROLOGIC DEFICITS. THE ADDITIONAL MEDICAL RECORDS SUBMITTED SHOWS THAT AT LEAST ON ONE OCCASION THE MEMBER DEVELOPED LOWER BACK SPASMS THAT

REQUIRED TRANSPORT TO THE SEWELLS POINT CLINIC BY AMBULANCE ON 17 DECEMBER 1996. THEREFORE, THIS IS CONSIDERED TO WARRANT A DISABILITY RATING OF 10% UNDER V.A. CODE 5295.

THE ABOVE RATINGS COMBINE TO 19%, WHICH ROUNDS TO 20%.

THE MEDICAL BOARD ADDENDUM FROM NEUROLOGY DATED 24 FEBRUARY 1997 GAVE THE ADDITIONAL DIAGNOSIS:

(4) MIGRAINE WITH AURA, INTRACTABLE, #3460.

CAREFUL REVIEW OF THE EVIDENCE AND HEALTH RECORDS SHOWS THAT THE DD FORM 2697 REPORT OF MEDICAL ASSESSMENT COMPLETED BY THE MEMBER ON 25 OCTOBER 1996 INDICATED ONLY THE KNEE AND BACK CONDITIONS LIMITED HER PERFORMANCE OF DUTIES. ALTHOUGH IT WAS AFTER THAT TIME THAT THE MEMBER EXPERIENCED HEADACHES THAT PROMPTED PLACEMENT ON S.I.Q. ON 1 NOVEMBER, 11 AND 16 DECEMBER 1996 AND 6 FEBRUARY 1997, THERE HAS BEEN NO FURTHER MEDICAL VISITS SPECIFICALLY FOR ACUTE HEADACHES SINCE THE 6 FEBRUARY VISIT AND SINCE THE MEMBER'S MEDICATIONS WERE ADJUSTED. THE HEARING PANEL DID NOT FIND THE MEMBER'S TESTIMONY SUFFICIENTLY CONVINCING THAT THIS PRECLUDES THE CONTINUED PERFORMANCE OF DUTIES. THEREFORE, THE MIGRAINE HEADACHES ARE CONSIDERED A CATEGORY III CONDITION THAT IS NOT SEPARATELY UNFITTING OR CONTRIBUTING TO THE UNFITTING CONDITIONS.

THERE IS NO EVIDENCE THAT THE CERVICAL SYNDROME PRECLUDES THE CONTINUED PERFORMANCE OF DUTIES. THEREFORE, IT IS ALSO CONSIDERED A CATEGORY III CONDITION.